Comments to the Board - External

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April 16, 2015 Board Meeting

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United States Senate
WASHINGTON, DC 20510

March 11, 2015

Peter Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Director Lee,

We are writing to ask that you add pregnancy as a qualifying life event for a special enrollment period outside of open enrollment season through Covered California. Prenatal care is critical for ensuring a healthy pregnancy and positive outcomes for both the baby and the mother. Especially since having a child is a qualifying life event, it makes sense to ensure that access to care is granted prior to birth.

According to the Centers for Disease Control and Prevention, prenatal care and continuous monitoring during a pregnancy are "key to preventing pregnancy-related complications and death." Babies whose mothers do not have access to prenatal care are three times more likely to be born underweight, and five times more likely to die than those who are born to mothers that do receive prenatal care. Prenatal care also offers crucial benefits to mothers—routine pregnancy care can prevent or mitigate serious conditions including preeclampsia, diabetes, and heart conditions.

Allowing women to purchase health insurance during pregnancy will increase access to care and has the potential to improve health, save lives, and reduce future health costs.

Thank you for your continued leadership in improving access to health care. We appreciate your consideration and look forward to working with you to address this issue.

Sincerely,

Dianne Feinstein
United States Senator

Barbara Boxer
United States Senator

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

April 10, 2015

The Honorable Patty Murray
United States Senate
Washington, DC 20510

Dear Senator Murray:

Thank you for your ongoing commitment to the Affordable Care Act and your leadership on efforts to promote women's access to maternity care. Your letter, signed by 36 of your colleagues, highlights the important association between early and regular maternity care and improved health outcomes for mothers and babies.

Maternity care has been a longstanding priority of the Department of Health and Human Services (HHS), and the Affordable Care Act further highlighted its importance by including such care as an Essential Health Benefit. Today, thanks to the Affordable Care Act, all individual market and small group plans that are not grandfathered or transitional—including qualified health plans on the Marketplaces—must cover maternity care services. Additionally, as you know, due to protections under the Affordable Care Act, women cannot be discriminated against on the basis of gender or pre-existing conditions when purchasing health insurance through the Marketplaces.

In your letter, you asked HHS to establish a Marketplace special enrollment period that would allow pregnant women to enroll in health insurance coverage. We have reviewed the statute and our regulations and have concluded that we do not have the legal authority to establish pregnancy as an exceptional circumstance.

It is important to note that Medicaid and the Children's Health Insurance Program (CHIP) continue to provide access to critical coverage for pregnant women. Women with low and moderate incomes can enroll in these programs at any time if they qualify. And, like all other qualified individuals, pregnant women can enroll in the Marketplace during annual open enrollment period.

We appreciate your input on furthering our mutual goals of improving access to quality health care services and promoting the health of mothers and babies. Your continued help in educating women of childbearing age about the health coverage options available to them—and when they may enroll in coverage through the Marketplaces, Medicaid, or CHIP—is critical.

We are committed to working with you and your colleagues to continue to improve women's access to coverage and early and regular prenatal care.

Sincerely,

Sylvia M. Burwell

COVERED CALIFORNIA

April 15, 2015

The Honorable Dianne Feinstein
United States Senate
331 Hart Senate Office Building
Washington, DC 20510

The Honorable Barbara Boxer
United States Senate
112 Hart Senate Office Building
Washington, DC 20510

Dear Senators Feinstein and Boxer,

Thank you for your letter regarding adding pregnancy as a qualifying life event for a special enrollment period outside of open enrollment season through Covered California. We appreciate the importance of this issue and welcome the opportunity to provide you with an update.

In a recent letter to Senator Patty Murray, the Secretary of Health and Human Services (HHS) concluded that HHS does not have the legal authority to establish pregnancy as an exceptional circumstance. Absent HHS guidelines, Covered California is unable to even consider making pregnancy a qualifying life event that would trigger a special enrollment period in the California Health Benefit Exchange.

Moving forward, we will continue to stress the importance of making sure that all consumers, regardless of health status, understand the benefits of enrolling during the Open Enrollment period as well as the potential tax penalties for not having coverage through the year.

Again, thank you for your continued support and leadership on Affordable Care Act implementation issues. Please feel free to reach out to me if I can provide you with additional information on this issue.

Sincerely,

Peter V. Lee
Executive Director

COVERED CALIFORNIA

March 6, 2015

The Honorable Ted Gaines
California State Capitol
Room 3056
Sacramento, CA 95814

Dear Senator Gaines,

I am writing to respond to your concerns regarding Covered California's contracting practices. I welcome the opportunity to address these issues as they relate to your request to the Joint Legislative Audit Committee.

The authorizing legislation that established Covered California recognized the challenges that the new state agency would face in implementing the key elements of the Affordable Care Act in California that could begin offering health coverage options in October 2013. These challenges included standing up a new organization, creating a new information technology system, implementing a very fast-track development of a contracting and selection process for health plans, and developing and implementing a broad-scale outreach and marketing program. In anticipation of the identified challenges and to help expedite some of the administrative processes that could have delayed needed implementation steps, the legislation provided specific exemptions from standard state contract procurement processes.

Consistent with its statutory obligation, the Covered California Board has adopted a policy that assures its ongoing and direct oversight of contracting. In addition to establishing clear policies and internal oversight, there are an array of independent oversight and monitoring vehicles of our contracting.

With regard to Covered California's contracting policies, the Board gave Covered California the flexibility of using standard state methods (such as primary or secondary requests for proposals), leveraging existing state procurement processes (such as the California Multiple Award Schedule (CMAS)) and developing methods that would assure best value selection of independent individuals and vendors to meet Covered California's needs.

Consistent with our Board's directive, Covered California uses a competitive process for the vast majority of its contracts. It has engaged in non-competitive contracts on occasion when necessitated by strict timelines or the need for individuals with unique expertise. Further, most of these contracts went to contractors who had either participated in competitive bidding processes or had demonstrated their ability to provide high quality work.

Finally, consistent with state statute, Covered California has adopted a conflict of interest code and an incompatible activities statement which include standards relating to "Outside Employment and Business Relationships" conflicts for Covered California officers and employees. Consistent with that policy, I want to be clear that I have no financial interests with individuals or organizations with which Covered California has contracted.

In your letter to the Joint Legislative Audit Committee, you state an audit could provide answers to eight questions. Covered California is committed to transparency and we welcome the opportunity to respond to the questions you raised below. The answers to those questions are as follows:

1. **What is the total dollar value of all "no-bid" contracts awarded by Covered California to private entities?**

   To date, $240,789,937.20 has been awarded to non-competitively bid contractors, which represents less than 21 percent of the dollar value of all contracts awarded since our inception. Of that amount, $213,633,791.00 was awarded to entities who had previously been evaluated by a competitive process or had previously provided services to Covered California under competitively awarded contracts and had demonstrated their ability to provide high quality work. Of the approximately $27 million remaining, over 60 percent was awarded to entities for consulting services and interim staff, around 19 percent was awarded to entities for expert research, and over 16 percent was awarded to the Health Consumer Alliance for consumer assistance.

2. **Which of these private entities employ or did employ, at the time these contracts were being deliberated or awarded, prior co-workers of others professionally associated with Covered California Executive Director Peter Lee?**

   As someone who has been involved in health care issues in California and nationally for over thirty years, I have had the benefit of professional relationships with a large number of individuals who work in a variety of sectors. This history means that I know many individuals who have participated in both competitively awarded and non-competitive contracts. My history and knowledge of individuals and more importantly of the skill sets and competencies that would potentially lead to effectively meeting Covered California's goals is one of my contributions to Covered California's success.

3. **What role did Peter Lee play in the awarding of Covered California's no-bid contracts?**

   To ensure transparency, the Covered California Board is required to approve all competitive solicitations over $1 million (approval required prior to release of solicitation), interagency agreements over $1 million, and non-competitive bids over $150,000. As a part of that process, my staff and I provide the Board with recommendations and justifications for all no-bid contracts to the Board prior to approval. I am responsible for assuring our compliance with our policies and assuring, including that there is adequate justification for engaging in non-competitive contracts and that staff have conducted robust processes to assure appropriate individuals or vendors are selected for all contracts.

4. **Did Covered California exercise sufficient oversight when awarding no-bid contracts?**

   Covered California has multiple oversight mechanisms of its contracting processes. In addition to the requirement for Board approval, all contract information is both submitted to the federal government, consistent with federal law and our contracts and contracting is subject to periodic review by the Center for Medicare and Medicaid Services (CMS). The California State Auditor has previously reviewed and will continue to monitor Covered California's contracting practices. As part of our practice of transparency, as discussed below, oversight is also provided by our making contracts and contracting information public, including pursuant to Public Record Act requests – which we do on a regular basis.

5. **Was the issue of Peter Lee's relationship with Leesa Tori, referenced in an Associated Press article in Fall 2014, disclosed to Covered California's Board or Counsel prior to awarding contract(s) to The Tori Group?**

   An example of the result of our public transparency processes is the fall article that referenced the Tori Group contract -- one out of many contracts Covered California has engaged in – to provide expert assistance with establishing the initial contracting and selection processes for Qualified Health Plans. The board was informed that I knew of Ms. Tori's work while she was at Pacific Health Advantage.

6. **Was the Tori Group the only company that could perform the duties of the $4.2 million contract(s) awarded to The Tori Group?**

Covered California urgently needed staff expertise to assist with initial contracting and selection processes for Qualified Health Plans and the establishment of Covered California's the Small Business Health Options Program (SHOP). This included helping Covered California engage in an initial competitive bidding process, contracting and oversight of the initial health plan relationships that brought 12 health plans to the Exchange, operating under a uniform contract, and offering plan pricing that surprised critics with their lower-than-expected rate increase. In order to expedite our ability to bring individual resources with deep health care contracting and negotiating skills onboard quickly, it was determined that a non-competitive procurement process was the most efficient option available in order to provide temporary resources as we transitioned towards a more permanent staffing structure.

The Tori Group is led by Leesa Tori who has over 10 years of experience in various roles in private sector health insurance organizations. She is a recognized expert whose experience includes leading product development at the Pac Advantage exchange, which combined the purchasing power of thousands of California small businesses in an offering of guaranteed issue health insurance to their employees a concept closely aligned with SHOP. Ms. Tori earned her Master's in Public Administration from the Harvard John F. Kennedy School of Government and has unique expertise in small group health insurance issues. The engagement of the Tori Group was extended to encompass the first renewal period based on the effective services provided by key staff under the contract. That renewal resulted in an average rate increase of only 4.2% and enabled Covered California to continue its model performance.

While it was, and in some cases continues to be, necessary for Covered California to utilize consultants and interim staff to launch our organization, this was far more the case in our early years in getting established. Moving forward we are both relying less on private contractors and less on the need to use non-competitive processes for the selection of individuals or vendors.

7. **Were other companies considered for the contracts awarded to the Tori Group?**

Given the tight timelines necessary for developing an initial health plan contracting and the SHOP program, it would not have been feasible for Covered California to go through the competitive contracting process in this instance.

While it is possible other organizations could have provided some of the implementation support services provided by the Tori Group, for Covered California to embark on a full competitive bid process in 2013 would have imperiled the appropriate focus Covered California had on the developing an effective competitive process by which it selected and monitored health plans to serve California's consumers.

8. **Does Covered California have other, no-bid contracts that have been awarded or are planned to be awarded, that have not been publicly disclosed?**

   The response to your first question includes all contracts that have been awarded through February of 2015. Moving forward, Covered California will post a quarterly report on our website at http://www.healthexchange.ca.gov/, which will include information on all of the contracts entered into.

   Covered California also adheres to the California Public Records Act that makes most contracts available to the public on request. The only exception is for contracts with participating health plans. Health plan contracts become public one year after the effective date of the contract, but are subject to standard terms and the premiums of those arrangements are public upon their being finalized.

I hope these responses address your concerns. Please let me know if I can be of further assistance.

Sincerely,

Peter V. Lee
Executive Director

Cc: Assemblymember Mike A. Gipson, Chair, Joint Legislative Audit Committee
Secretary Diana Dooley, Chair, Covered California Board

DAVE JONES
Insurance Commissioner

April 14, 2015

Secretary Diana Dooley
Chair, Covered California and Board Members
1601 Exposition Blvd.
Sacramento, CA 95815

Re: Prescription Drug Formulary Cap Recommendations – Vote on Covered California's Standard Plan Design

Dear Chairperson Dooley and Covered California Board Members,

Your decision as to whether you will allow health insurers and health plans to place specialty drugs into a "high-cost tier" and if so, what out-of-pocket costs for policyholders must pay to obtain these drugs is critical to California consumers, as such a potentially discriminatory benefit plan design would place vital life-sustaining drugs out of reach for many Californians.

I have appreciated the opportunity for the Department of Insurance to work on this issue with Covered California, your staff, and the members of the Specialty Drug Work Group. During discussions leading to Covered California's staff recommendation, we have asked Covered California to establish a monthly cap of $200 on out-of-pocket costs for specialty tier drugs in order to spread the cost sharing amount over the coverage year. Unfortunately, however, your staff's recommendation to cap out-of-pocket expenses for specialty drugs at $500 per prescription per month falls short of what is needed. Capping out-of-pocket expenses at this level creates an affordability barrier for the average consumer, particularly those who struggle with chronic conditions that require multiple prescriptions. We urge Covered California instead to adopt a cap of $200 per prescription per month for specialty drugs, which we believe would provide considerable relief for those affected by the high costs of specialty drugs by spreading their costs over the plan year.

Discriminatory Benefit Design

Your proposed Standard Benefit Plan Design creates a 4-tier pharmacy benefit in which the fourth tier is, for most metal levels, treated differently than drugs on the other tiers. For example in the Silver plan (which is the plan with the highest number of policyholders in the individual market), the copay in tiers 2 ($50) and 3 ($70) are subject to a pharmacy deductible of $250 individual/$500 family, while tier 4 drugs are subject to a 20% coinsurance of up to $500 per

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prescription, which is applied over and above the pharmacy deductible. The Bronze (the plan with the second highest number of policyholders and the highest number of those who don't qualify for federal premium assistance) has a $500 maximum deductible per prescription for all tiers. In the Platinum plan, the first three tiers involve a copay, while the fourth tier involves a 10% coinsurance capped at $300 per script. In the Gold plan, a 20% coinsurance level for the fourth tier is capped at $500 per script.

The proposed Standard Benefit Plan Design sets criteria for Tier 4 drugs at footnote 19: one such criterion is the cost of the drug. Drugs with a cost in excess of $600 can be placed in Tier 4. This criterion can result in drugs vital to those with HIV/AIDS, multiple sclerosis, rheumatoid arthritis, Hepatitis C and other chronic or life-threatening conditions being placed in Tier 4, and thus subject to cost-sharing different from all other drug tiers. While footnote 20 provides that, in situations where there are at least 3 drugs in a drug class, at least one must not be in Tier 4, this provision does nothing to protect those with conditions for which there are less than three drugs.

Insurance Code §10753.05(h)(3) prohibits "...marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminate based on the individual's....health conditions." Cost-sharing requirements that place medically necessary care out of the reach of individuals with certain health conditions is discriminatory. In the last two years, as we have implemented the new Affordable Care Act (ACA) rules, the Department of Insurance has rejected some plan designs with co-insurance requirements on specialty drugs because of their discriminatory impact on those with certain medical conditions. We are concerned that the Standard Benefit Plan Design, as currently proposed, also implicates California anti-discrimination statutes because of its potentially disparate impact on the enrollment of those with significant health needs. In particular, the Silver plan, which imposes copays with a $250 maximum annual deductible in the first three tiers, imposes coinsurance with a cap of $500 per script.

It is also worth noting that in the preamble to the Federal Notice of Benefit and Payment Parameters for 2016 final rule, CMS sends a clear message about the types of benefit designs that would be prohibited under 45 CFR §156.125. This guidance is helpful to the Department of Insurance in highlighting areas where regulators may find discriminatory practices. It notes that "placing most or all drugs for a certain condition on a high cost tier without regard to the actual cost the issuer pays for the drug may often be discriminatory in application when looking at the totality of the circumstances, and therefor prohibited." (80 Federal Register 10823, Feb. 27, 2015)

The recommended cap does not ameliorate our concerns that significantly higher out-of-pocket costs borne by consumers using specialty drugs is, in fact, discriminatory.

Impact on Consumers

There is a significant body of research indicating that cost can significantly impact drug adherence for those with chronic conditions. We are therefore concerned that such a high cap will put important prescription drugs out of reach of many consumers, leading to decreased

treatment compliance and increased adverse health outcomes. For example, one research study found decreased treatment compliance when out-of-pocket expenses for certain multiple sclerosis treatments were greater than $200[1]. Most studies demonstrate that adherence drops off significantly when the cap is greater than $200.

A recently released report by the Kaiser Family Foundation (KFF) entitled, *Consumer Assets and Patient Cost Sharing*[2] made it clear that households are already struggling to meet their out-of-pocket expenses. According to the report, "Looking at the out-of-pocket limits, most households do not have sufficient liquid financial assets to meet either the lower or the higher limit. The percentage of households who have both low incomes and enough assets to meet either of the out-of-pocket limits is very low."[3] Further, they concluded that for families with incomes between 100% and 200% of Federal Poverty Level (FPL), "Only 32% of households with incomes between 100% and 250% of poverty can meet the lower deductible amounts, while one-in-five can meet the higher deductible amounts."[4]

It is not only lower income households who feel this squeeze. The report found that, "substantial shares of households with incomes between 250% and 400% of poverty would be unable to meet even the lower out-of-pocket limits with their current resources, and meaningful shares of households with incomes over 400% of poverty would have problems as well."[5]

The KFF report clearly demonstrates that many families of low and moderate incomes are struggling to meet their annual deductibles and therefore cannot afford to fill prescriptions for specialty drugs if their out-of-pocket cost is $500 per prescription per month.

Impact on Actuarial Value and Premium

I asked our actuaries to run options of capping the dollar amount per drug/per month through the 2016 Actuarial Value (AV) Calculator. They reported to me that capping Tier 4 coinsurance payments at $200 per prescription would have almost no impact on the AV. The plans would thus still comply with the required AV range for each metal level and significant changes in premium would not be justified. Even when your staff collected information from health carriers about what level of premium increase they would propose, the information you received from the health insurance carriers indicated that for some of them, capping the out-of-pocket cost for specialty drugs at $200 would have no impact on premium, and for others the maximum increase proposed was .77% for 2016 – the plan year for which you are setting the Standard Benefit Design. This proposed premium increase by the carriers of 0 -.77% associated with the $200 cap I am urging you to adopt is almost identical to the proposed price increase of 0 - .70 % for setting the cap at $500 as you propose.

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[1] Gleason, P. et al. (2009) Association of Prescription Abandonment with Cost Share for High-Cost Specialty Pharmacy Medications. Journal of Managed Care Pharmacy, 15(8):648-58.
[2] http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/
[3] Ibid, p6
[4] Ibid, p7
[5] Ibid, p13

In addition to our internal calculations, Milliman produced a recent report entitled, *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*, where they used California exchange data to model the impacts of per-prescription caps set between $100 and $200 and an annual prescription drug out-of-pocket (OOP) maximum set at 20% of the total OOP. The report concluded what our actuaries reported: "The average plan member would be expected to see very little change in their total expected healthcare spending (premiums plus out-of-pocket costs for medical and pharmacy services) upon implementation of any of the potential benefit design changes."[6]

Efforts in Other States to Prevent Specialty Drugs from Being Out of Reach for Policyholders

My recommendation for a $200 cap for specialty drugs is well in line with caps implemented by other states including Maryland, Florida, Delaware, Louisiana, and Montana. These states have caps between $100 and $250 per prescription per month. Colorado has a $500 cap, but they are by far the outlier. In 2010, New York went even further out of concern for policyholders with chronic conditions. Instead of implementing a cap, they prohibited specialty tiers altogether which, in effect, limits maximum cost-sharing to those of non-preferred brand name drugs.

Finally, my recommendation is consistent with ongoing legislative efforts in 5 states and the District of Columbia including Oregon, Kansas, Oklahoma, Illinois, and Connecticut. In fact, four of the five of those states are recommending caps of $100 per prescription per month. Given that Covered California is currently setting the Standard Benefit Design for California for both inside and outside the Exchange, we would urge that you set the $200 per prescription cap for specialty drugs.

Conclusion

If approved as recommended by your staff, the Covered California Standard Benefit Plan Design will put many Californians with chronic medical conditions in the position of being expected to pay thousands of dollars in the first few months of their policy year in order to receive life-saving prescription drugs. Of note, a $200 copay cap per prescription is consistent with the proposed benefit plan design for the Silver 100%-150% and 160%-200% FPL plans, showing such a cap can be achieved in the California context. We also know from California's $200 cap on the cost of oral cancer medications that this can be achieved.

The impacts of non-adherence to their prescription drug regime go beyond the health of the individual. Nationally, the annual cost of non-adherence resulting in emergency room visits and other preventable medical expenses was $290 billion or 13% of total health expenditures[7]. For people with chronic conditions that require specialty drugs, adopting a $200 cap is a prudent cost-saving measure for the system as a whole.

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[6] Milliman. Et al (2015). *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*. p3.

[7] New England Healthcare Institute. (2009). *Thinking outside the Pill Box: A System-Wide Approach to Improving Patient Medication Adherence for Chronic Disease*.

A cap of $200 on specialty drugs would have almost no impact on actuarial value while providing a positive impact on consumer affordability and adherence to complicated drug regimens. Further, other states have demonstrated that it can be done successfully; such a cap is also consistent with what many insurers already do in the large group market.

I urge you to modify your staff's recommendation and impose a $200 cap per prescription on the out-of-pocket costs for specialty drugs, for the benefit of consumers throughout California who have health conditions that necessitate access to these drugs.

Sincerely,

DAVE JONES
Insurance Commissioner

March 23, 2015

Peter Lee, Executive Director
Diana Dooley, Chair
Members of the Board
California Health Benefit Exchange Board

RE: Serving the Needs of Children in Covered California

Dear Mr. Lee, Chairwoman Dooley, and Members of the Board:

Since Covered California was first established, our California Children's Health Coverage Coalition has consistently advocated for policies and procedures that ensure the needs of children enrolled in Covered California plans are met and they are able to access the health care they need. As Covered California continues to implement its second year of enrollment, we appreciate this opportunity to stress the importance of examining the enrollment and access experiences of children and their families. Although children comprise less than six percent of the Covered California population, it is important that the California Health Benefit Exchange Board has the necessary information to understand how children are served by the Exchange.

In follow-up to a meeting our coalition had with Covered California staff nearly a year ago, we again ask for more detailed data and monitoring related to children. In our view, enhanced data is needed to ensure that Covered California and its contracted Qualified Health Plans are meeting the needs of children and delivering quality care that improves health outcomes for kids.

DATA

At our coalition's May 2014 meeting with staff, we discussed the need to know not only how many individuals under age 18 are receiving coverage through Covered California, but a further age breakdown (for example: 0-3 years, 4- 12 years, 12-18 years). Additionally, we expressed an interest in knowing the distribution of Covered California child enrollees by plan, by geographic area of residence, and by receipt of subsidies. And in the spirit of moving forward with the Board's oft expressed desire to assess the "quality" of the enrollee's experience, we remain interested in knowing how Covered California plans to survey families' enrollment, plan utilization, and experiences. We are especially interested in more information regarding the number and experiences of "mixed-program" families- that is, members who transition in and out of or between coverage programs, or are served in two programs such as Medi-Cal and Covered California. We hope to have an opportunity in the next few months to contribute to the dialog about how to measure not only the ease of the consumer enrollment

experience, but also how enrolled children are using their coverage, accessing needed providers in a timely way.

We have also indicated a need to review and understand the dependent data from the SHOP particular to children, since many children have traditionally received their coverage through employer-sponsored insurance. For example, it would be valuable to have more complete information about dental coverage selection by SHOP dependents. It was discouraging to recently learn that fewer than 5 % of SHOP dependents had dental coverage. As you are aware, we have suggested that enrollee education about the availability of dental coverage is needed in order to ensure maximum utilization; perhaps that outreach should be extended to SHOP enrollees, as well. Additionally, we want to ensure that the SHOP employee application continues to allow SHOP employees to indicate if they have dependents needing coverage. Further, we would appreciate an update on how many SHOP employees checked that box, and the results of Covered California staff follow-up.

MONITORING

It has been noted that some plans offered by Covered California may have narrow provider networks that may inhibit a child from seeing an appropriate provider or specialist in a timely manner. Access to pediatric and child-serving providers is particularly critical for children, for whom preventive care services, immunizations, and regular and timely developmental and behavioral health screenings can significantly shape their future health.

We wholeheartedly agree with the Executive Director's the March 5, 2015 report that highlighted the Board's "pillars of strategy" priorities. We agree it is important to prioritize access to needed care and to ensure that "consumers receive the right care at the right time." We strongly encourage your efforts to monitor and assess plan utilization, so that we know if the fundamental and particular health care needs of children are being met and they are able to access the full range of health care benefits and services. As Covered California determines the processes for monitoring enrollee access and utilization, and establishes quality measures, we ask that special consideration be given for children within any special health care needs. As an "active purchaser", Covered California has a responsibility to ensure that its plans provide children with access to high quality care.

Certainly, the success of Covered California will not rest simply on the number of enrolled individuals, but rather on a demonstration of improved health outcomes, and greater well-being of California's families.

It is exciting to have reached such impressive enrollment numbers in Covered California; however, it is now time to be confident that Covered California coverage translates into care. Because the health of California's children is so important, we anticipate requesting a follow-up meeting with Covered California staff to further pursue these important data and monitoring matters on behalf of children in Covered California plans.

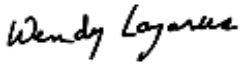
We appreciate the attention given to Covered California's youngest enrollees and look forward to continuing our work together. If you wish to discuss further, please feel free to contact Kathryn Dresslar at The Children's Partnership at 310-260-1220 or kdresslar@childrenspartnership.org.

Sincerely,

Ted Lempert
President
Children Now

Corey Timpson
Director
PICO California

Anna Hasselblad
Interim Executive Director
California Coverage & Health Initiatives



Wendy Lazarus
Founder and Co-President
The Children's Partnership

Peter Manzo
President & CEO
United Ways of California

Alex Johnson
Executive Director
Children's Defense Fund – California

cc: David Panush, External Affairs Director
Katie Ravel, Program Policy Director

January 27, 2015

Peter Lee
Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Dear Mr. Lee:

You may have read the disturbing reports over the past week of personal information – including the age, income, pregnancy status, tobacco use and ZIP code of consumers applying for health insurance coverage – being disclosed to third party vendors at Healthcare.gov. The *Associated Press* identified at least 50 third parties collecting and gathering information in some capacity from the website. HHS has announced some improvements to security at Healthcare.gov, however more steps are necessary to safeguard consumers' privacy.

We are concerned that the same security failures and unnecessary sharing of consumers' private information with third party vendors may be occurring at CoveredCa.gov. It is particularly important during these last few weeks of open enrollment that consumers be comfortable with the privacy safeguards in place.

It is not enough to use generic terms like "website functionality" to describe how you share information with third parties. In order to assure consumers that their private health information will be protected if they apply for health coverage through the exchange, we ask that you disclose the following:

- How many, and which, third-party companies are operating on CoveredCa.gov?
- What information are those third-party companies collecting, and for what purpose?
- Does CoveredCa.gov have security loopholes like those at Healthcare.gov that allowed third-party companies to obtain personal information like pregnancy, smoking status and ZIP Code submitted by consumers when applying for health insurance?
- Does Covered California honor do not track requests from consumers' web browsers?

A second area of concern is data collected by Covered California and used or shared for purposes other than providing health insurance to consumers. For example, your privacy policy states that you can share consumer information for purposes of research or public health, and suggests that you may use it for fundraising purposes. We ask that you further disclose:

- What type of information could be shared for research, public health, or fundraising purposes?
- What are examples of each of these purposes?

- Does Covered California ever give personally identifiable information, or information that could be easily re-identified, to third parties in these cases?
- What type of information does Covered California collect that is not provided directly by the consumer? For example, what information does Covered California collect from health insurance companies? Does such information get aggregated with data provided by individual consumers, and for what purposes?

Considering the public outcry when it was revealed that Covered California shared consumer information with insurance brokers without disclosure in 2013, you should understand better than most Californians' deep sensitivity to privacy concerns. Detail beyond your privacy policy of how consumers' private health information is collected, shared and used by Covered California is needed to ensure the hundreds of thousands of consumers that will visit CoveredCa.gov before the February 15 enrollment deadline that their privacy will be protected.

I look forward to your response.

Sincerely,

Carmen Balber

COVERED CALIFORNIA

March 10, 2015

Ms. Carmen Balber
Consumer Watchdog
2701 Ocean Park Blvd., Suite 112
Santa Monica, CA 90405

Dear Ms. Balber,

Thank you for contacting me with your concerns regarding the disclosure of personal information to third-party companies. I welcome this opportunity to update you on how Covered California protects its consumers and ensures that they can shop, compare and enroll in health coverage with every confidence that we are taking the necessary precautions to protect their personal information.

At Covered California, we understand that public trust is essential and must be established by adopting strong security and privacy protections for our information technology (IT) systems. There is a complex array of regulations and requirements that govern federal and state protection of IT security and privacy. We strictly adhere to these state and federal regulations, including those set forth by the Affordable Care Act (45 C.F.R. § 155.260) and California Information Practices Act. We also abide by Minimum Acceptable Risk Standards for Exchanges (MARS-E), and National Institute of Standards and Technology 800-53 guidelines.

The following responses address your specific concerns:

1. **How many, and which, third-party companies are operating on CoveredCa.gov?**

There are no third-party companies that operate on Covered California's websites (the www.CoveredCa.com, www.healthexchange.ca.gov and the CalHEERS website).

Covered California does use Google Analytics to analyze website traffic and review web "hits" on a page or link. BrightTag, a management tool that works with Google Analytics, is also used to gather information on website "clicks."

We use these technologies to better the consumer experience by gathering web-traffic information that helps our understanding of how consumers navigate through our sites; no personally-identifiable information (PII) is collected. Further, the utilization of these technologies is controlled and operated by Covered California staff.

2. **What information are those third-party companies collecting, and for what purpose?**

Covered California does not have third-party companies that capture any PII from our consumers. As mentioned, Google Analytics and BrightTag are used to gather information regarding the number of consumers that view the content on our websites. This information is only used internally to improve the functionality of our websites by understanding how consumers navigate through them.

3. **Does CoveredCa.gov have security loopholes like those at Healthcare.gov that allowed third-party companies to obtain personal information like pregnancy, smoking status and ZIP Code submitted by consumers when applying for health insurance?**

Covered California is up-to-date and in compliance with all state and federal regulations. Each of our contractors—and consistent with federal law under the Affordable Care Act (ACA)–are only permitted by contract and by law to use the information Covered California provided to them for the purpose of helping the consumer enroll in health care coverage through Covered California, and are required to abide by the same security requirements to safeguard the privacy of consumer information that Covered California must follow under federal and state laws.

No third-party companies or services, including Google Analytics and BrightTag, obtain *any* PII like pregnancy, smoking status, and zip codes submitted by consumers when applying for health insurance.

4. **Does Covered California honor "do not track" requests from consumers' web browsers?**

Yes. When a consumer makes a "do not track" request, their cookies are disabled and they are still be able to navigate through our websites.

5. **What type of information could be shared for research, public health, or fundraising purposes?**

Covered California only shares consumers' personal information (PII) for the sole purpose of providing or improving upon certain enumerated minimum Exchange functions required by the Affordable Care Act (ACA) regulations or federal agencies.

These "minimum functions" include setting competitive rates for participation in the Exchange marketplace, facilitating consumer enrollment into qualified health plans (QHPs) and Medi-Cal, and engaging in community outreach and education activities. Under those circumstances, Covered California strictly follows privacy and security standards required under the ACA regulations and only discloses the minimum information necessary to help fulfill those functions.

Research. Certain consumer eligibility and enrollment information may be shared with other agencies or certified representatives only when the research is needed to help accomplish an Exchange function required under the ACA regulations.

Public Health. The types of consumer PII shared by Covered California for public health purposes include income and coverage information and pregnancy and disability status, which are only shared with applicable State agencies to enable them to administer specific public health programs.

Fundraising. Covered California *does not* provide or utilize PII or any other consumer information for fundraising purposes.

6. **What are examples of each of these purposes?**

See above.

7. **Does Covered California ever give personally identifiable information, or information that could be easily re-identified, to third parties in these cases?**

Covered CA only provides the minimum consumer PII necessary to enable state agencies or authorized representatives to fulfill required minimum Exchange functions.

8. **What type of information does Covered California collect that is not provided directly by the consumer? For example, what information does Covered California collect from health insurance companies? Does such information get aggregated with data provided by individual consumers, and for what purposes?**

Information related to health insurance enrollment and eligibility for insurance affordability programs may be collected from governmental agencies and qualified health plans. In each instance, the collection of this information is necessary to enable Covered California to fulfill a required minimum Exchange function and any such information collected is strictly used for this sole purpose.

Please let me know you'd like additional information to address your concerns regarding our privacy and PII security policies.

Sincerely,

Peter V. Lee
Executive Director

cc: Covered California Board

April 14, 2015

Diana Dooley, Chair
Peter Lee, Executive Director

Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

Re: Staff Recommendation on Cost Sharing for Prescription Drugs

Dear Ms. Dooley and Mr. Lee,

Our organizations write to offer comment on the staff recommendation on cost sharing for prescription drugs for the 2016 benefit year.

While the Board action requiring transparency of formularies and the placement of some high cost drugs on lower benefit tiers offer improvements for consumers, consumers need protection on cost sharing for prescription drugs. Today, because of the co-insurance for the top tier of drug coverage, some consumers pay as much as $6,250 for a single month's prescription for a single drug.

Almost 90% of the enrollment of Covered California is below 400% FPL, $48,000 for a single individual or $97,000 for a family of four. Asking Californians living on such modest incomes to spend over $6,000 for a single prescription is unrealistic and inhumane. There is an ample body of peer-reviewed literature on medication adherence that confirms what common sense suggests: people will not fill the prescription, will skip doses, cut pills in half or otherwise fail to take their prescriptions as prescribed.

Support Maximum Cap on Prescription Drug Cost Sharing, But at Lower Level

Our organizations support imposing a cap on co-insurance prescription drug cost sharing. We appreciate that for some consumers, such as those with HIV/AIDS or

other conditions where specialty drugs cost a few thousand dollars, co-insurance of 20% would amount to $200-$1,000.

However, we have very serious concerns about the maximum caps proposed by staff. These maximum caps are $500 for most standard benefit designs and $200 for the lower cost sharing reduction products, Silver 87 and Silver 94, available to consumers with incomes 100%FPL-200%FPL.

Covered California Enrollees: Moderate Income, Modest Resources

A recent national report[1] found that consumers making 100%FPL-250%FPL have median liquid assets of $326 and consumers making 251%FPL-400%FPL have median liquid assets of $2,089. A cap of $200 means that we are asking people living on 100%FPL-200%FPL to spend all of their liquid assets in two months. A cap of $500 means that we are asking moderate income consumers to spend their liquid assets in four months.

Many of the consumers affected, such as those with lupus, multiple sclerosis, HIV/AIDS, and other conditions not only take multiple medications but take them for years, not a few weeks or months. Such consumers have other health care costs, such as doctor visits and lab tests to monitor their condition. Having a major illness should not impoverish people, particularly if they bought health insurance.

Negligible Impact of Caps on Premiums and Actuarial Value for 2016

For 2016, the proposed caps have negligible impact on premiums or actuarial values. The staff recommendation reflects caution about the out-year impacts for future years, not the impacts for 2016. This caution about out-year impacts reflects the possible emergence of other very high cost drugs to treat other conditions.

Lower Caps Appropriate for Covered California Enrollment

Our organizations support maximum caps on prescription cost sharing but at a lower level than that proposed by staff. We propose caps of $100 for those on cost sharing reduction products (who live on $1,000-$2,000 a month for a single individual) and caps of $200 per 30-day prescription for those above those income levels, with corresponding adjustments for Platinum tier products.

Monitoring of Medication Adherence

Whatever cap the Board approves, we also ask that the Qualified Health Plan contracts be amended to require monitoring of medication usage for specialty drugs, broken out by major condition and done separately for the lowest income consumers and those of more moderate incomes. We urge that you track adherence on two key

[1] Claxton et al, Consumer Assets and Patient Cost Sharing, March, 2015, http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/

variables, both whether patients that start a prescribed regimen continue to adhere to it and also whether prescriptions are actually filled and thus the recommended care is actually commenced. Tracking both is necessary to determine whether high cost sharing is deterring consumers from getting the care they need.

High cost drugs vary from $1,000 to $5,000 in cost to the plan with only a few super-high cost drugs costing $40,000 or more. The needs of consumers also vary depending on the standard of care for their condition. The literature we have reviewed indicates that consumer cost sharing above $200 or $250 per prescription results in lack of adherence to medication regimens but there is some variation by condition.

Summary

Our organizations support the concept of a cap on co-insurance for prescription drugs. We ask that the cap be a lower amount, $100 for those who make 100%FPL-200%FPL and $200 for those who make more (with corresponding adjustments for Platinum products). We ask that whatever caps are approved, the plan contracts be amended to require monitoring of medication usage to determine whether consumers are discouraged by high cost sharing from taking the medications they need.

Sincerely,

California Pan-Ethnic Health Network
Consumers Union
Health Access
National Health Law Program
Project Inform
Western Center on Law & Poverty